

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0027987</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER													
Facility Name: <u>FAIRHAVEN CHRISTIAN RETIREMENT CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.													
Address: <u>3470 N. ALPINE RD.</u> <u>ROCKFORD</u> <u>61114</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.													
County: <u>WINNEBAGO</u>															
Telephone Number: <u>(815)877-1441</u> Fax # <u>(815)877-2040</u>															
IDPA ID Number: <u>36-2606227001</u>															
Date of Initial License for Current Owners: <u>03/01/68</u>															
Type of Ownership:															
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT															
<input checked="" type="checkbox"/> Charitable Corp.															
<input type="checkbox"/> Trust															
IRS Exemption Code <u>501(C)(3)</u>															
<input type="checkbox"/> PROPRIETARY															
<input type="checkbox"/> Individual															
<input type="checkbox"/> Partnership															
<input type="checkbox"/> Corporation															
<input type="checkbox"/> "Sub-S" Corp.															
<input type="checkbox"/> Limited Liability Co.															
<input type="checkbox"/> Trust															
<input type="checkbox"/> Other															
<input type="checkbox"/> GOVERNMENTAL															
<input type="checkbox"/> State															
<input type="checkbox"/> County															
<input type="checkbox"/> Other															
In the event there are further questions about this report, please contact: Name: <u>JEFF REIERSON</u> Telephone Number: <u>(815)877-1441 X305</u>		<table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2"></td> <td>(Type or Print Name) <u>THOMAS T. BLEED</u></td> </tr> <tr> <td>(Title) <u>EXECUTIVE DIRECTOR</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) <u>()</u> Fax # ()</td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>THOMAS T. BLEED</u>	(Title) <u>EXECUTIVE DIRECTOR</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # ()
Officer or Administrator of Provider	(Signed) _____														
	(Date) _____														
	(Type or Print Name) <u>THOMAS T. BLEED</u>														
	(Title) <u>EXECUTIVE DIRECTOR</u>														
Paid Preparer	(Signed) _____														
	(Date) _____														
	(Print Name and Title) _____														
	(Firm Name & Address) _____														
	(Telephone) <u>()</u> Fax # ()														
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001		Phone # (217) 782-1630													

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER# 0027987 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>96</u>	Intermediate (ICF)	<u>96</u>	<u>35,040</u>	3
4		Intermediate/DD			4
5	<u>135</u>	Sheltered Care (SC)	<u>135</u>	<u>49,275</u>	5
6		ICF/DD 16 or Less			6
7	<u>231</u>	TOTALS	<u>231</u>	<u>84,315</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>9,496</u>	<u>21,965</u>		<u>31,461</u>	10
11	ICF/DD					11
12	SC		<u>27,124</u>		<u>27,124</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,496</u>	<u>49,089</u>		<u>58,585</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.48%

D. How many bed-hold days during this year were paid by Public Aid?

9 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 03/01/68

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT # 0027987 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	596,999	56,738	16,141	669,878		669,878		669,878		1
2	Food Purchase		445,996		445,996	(11,063)	434,933	(13,251)	421,682		2
3	Housekeeping	231,552	47,966	10,731	290,249		290,249		290,249		3
4	Laundry	144,389	30,603	10,762	185,754		185,754		185,754		4
5	Heat and Other Utilities			314,387	314,387	(5,000)	309,387	(20,478)	288,909		5
6	Maintenance	253,025	60,334	237,699	551,058		551,058	(10,633)	540,425		6
7	Other (specify):*			132,242	132,242		132,242		132,242		7
8	TOTAL General Services	1,225,965	641,637	721,962	2,589,564	(16,063)	2,573,501	(44,362)	2,529,139		8
	B. Health Care and Programs										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	2,551,635	114,290	54,014	2,719,939		2,719,939		2,719,939		10
10a	Therapy										10a
11	Activities	122,898	6,129	5,983	135,010		135,010		135,010		11
12	Social Services	27,536		12,103	39,639		39,639		39,639		12
13	Nurse Aide Training										13
14	Program Transportation			2,331	2,331		2,331	(466)	1,865		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,702,069	120,419	90,031	2,912,519		2,912,519	(466)	2,912,053		16
	C. General Administration										
17	Administrative	195,192			195,192		195,192		195,192		17
18	Directors Fees										18
19	Professional Services			95,007	95,007	(8,134)	86,873	(23,245)	63,628		19
20	Dues, Fees, Subscriptions & Promotions			38,096	38,096	998	39,094	(18,684)	20,410		20
21	Clerical & General Office Expenses	139,172	26,919	19,693	185,784		185,784	(1,824)	183,960		21
22	Employee Benefits & Payroll Taxes			915,804	915,804	18,199	934,003		934,003		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,724	18,724		18,724	(13,097)	5,627		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			92,611	92,611	(15,000)	77,611	(138)	77,473		26
27	Other (specify):*			5,113	5,113		5,113	(5,113)			27
28	TOTAL General Administration	334,364	26,919	1,185,048	1,546,331	(3,937)	1,542,394	(62,101)	1,480,293		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,262,398	788,975	1,997,041	7,048,414	(20,000)	7,028,414	(106,929)	6,921,485		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER #0027987 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			523,414	523,414	6,444	529,858	(108,911)	420,947			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,722	27,722		27,722	(27,722)				32
33	Real Estate Taxes			217,040	217,040		217,040	(217,040)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,373	1,373		1,373		1,373			35
36	Other (specify):* Amortize Bond Costs			12,448	12,448		12,448		12,448			36
37	TOTAL Ownership			781,997	781,997	6,444	788,441	(353,673)	434,768			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					5,000	5,000		5,000			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*			807,585	807,585	8,556	816,141		816,141			43
44	TOTAL Special Cost Centers			860,145	860,145	13,556	873,701		873,701			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,262,398	788,975	3,639,183	8,690,556		8,690,556	(460,602)	8,229,954			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **FAIRHAVEN CHRISTIAN RETIREMENT CENTER**# **0027987**

Report Period Beginning:

01/01/2003

Ending:

12/31/2003**VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,251)	Line2		4
5	Telephone, TV & Radio in Resident Rooms	(20,478)	Line5		5
6	Rented Facility Space	(10,633)	Line6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,229)	Line32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(25,493)	Line32		14
15	Non-Care Related Owner's Transactions	(108,911)	Line30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(13,097)	Line24		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,800)	Line27		24
25	Fund Raising, Advertising and Promotional	(18,684)	Line 20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,824)	Line21		28
29	Other-Attach Schedule Lines 14,19,26,27,33	(244,202)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (460,602)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (460,602)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		5,000	Line 5	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Dup Insur	X		15,000	Line26	45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 20,000		47

STATE OF ILLINOIS
FAIRHAVEN CHRISTIAN RETIREMENT CENTER

Page 5A

ID# 0027987
Report Period Beginning: 01/01/2003
Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Gas for non-care vehicles	\$ (466)	14
2	Insurance for non-care vehicles	(138)	26
3	Flowers & decorations, miscellaneous	(3,313)	27
4	Bond trustee costs	(23,245)	19
5	Real estate taxes-main building	(217,040)	33
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(244,202)	49

Summary A

12/31/2003

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(217,040)	0	0	0	0	0	0	0	0	0	0	(217,040)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(217,040)	0	0	0	0	0	0	0	0	0	0	(217,040)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(244,202)	0	0	0	0	0	0	0	0	0	0	(244,202)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **FAIRHAVEN CHRISTIAN RETIREMENT** # **0027987** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER # 0027987 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	NONE				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$										
2																			
3																			
4																			
5																			
	Working Capital																		
6	Amcore Bank-Line of Credit	X		Operating Expenses	None	5/7/03	500,000	125,000	5/7/04	0.0400	3,046	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 500,000	\$ 125,000				\$ 3,046	9						
	B. Non-Facility Related*																		
10	City of Rockford Bonds		X	Construction	None	02/22/00	2,500,000	2,050,000	2/01/2013	0.0120	24,676	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related				None		\$ 2,500,000	\$ 2,050,000				\$ 24,676	14						
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 2,175,000				\$ 27,722	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **FAIRHAVEN CHRISTIAN RETIREMENT CENTER**# **0027987** Report Period Beginning: **01/01/2003** Ending: **12/31/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$ 410,025	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 417,845	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 7,820	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 422,023	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ * 0.00	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 380,827	8	
	1999 378,723	9	
	2000 388,614	10	
	2001 398,084	11	
	2002 417,845	12	
* Since the nursing home portion of our facility is exempt from real estate taxes, all other tax related to the main building would not be allowable and is therefore, adjusted out of the total costs on this report.			
		13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
		14	PLUS APPEAL COST FROM LINE 5 \$ 14
		15	LESS REFUND FROM LINE 6 \$ 15
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRHAVEN CHRISTIAN RETIREMENT CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0027987

CONTACT PERSON REGARDING THIS REPORT Jeff Reiersen

TELEPHONE (815) 877-1441 FAX #: (815) 877-2040

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>152B028B</u>	<u>Main Building</u>	\$ <u>212,121.00</u>	\$ <u>none</u>
2. <u>152B030</u>	<u>3488 N. Alpine</u>	\$ <u>7,915.00</u>	\$ <u>none</u>
3. <u>152B051</u>	<u>Land by Alpine</u>	\$ <u>399.00</u>	\$ <u>none</u>
4. <u>149C081B</u>	<u>Verde Lane</u>	\$ <u>88.00</u>	\$ <u>none</u>
5. <u>149C052,053,054</u>	<u>Rolling Meadow/Terrace View Dup.</u>	\$ <u>258,102.00</u>	\$ <u>none</u>
6. <u>152B031</u>	<u>Garden Lane Duplexes</u>	\$ <u>40,712.00</u>	\$ <u>none</u>
7. <u>152B152,153,154,155,156</u>	<u>Garden Lane Duplexes</u>	\$ <u>26,315.00</u>	\$ <u>none</u>
8. <u>152B157,158,159,161,162</u>	<u>Garden Lane Duplexes</u>	\$ <u>28,970.00</u>	\$ <u>none</u>
9. _____	_____	\$ _____	\$ _____
10. <u>SEE ATTACHED PAGE 10B FOR</u>	<u>EXPLANATION</u>	\$ _____	\$ _____
TOTALS		\$ <u><u>574,622.00</u></u>	\$ <u><u>none</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:
 159,494

B. General Construction Type:
 Exterior
 Brick
 Frame
 Steel
 Number of Stories
 3

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Main Building	871,200	1965	\$ 62,304	1
2					2
3	TOTALS	871,200		\$ 62,304	3

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94		1967	1967	\$ 1,115,078	\$ 27,041	40	\$ 27,041		\$ 993,202	4
5	76		1973	1973	\$ 1,051,996	\$ 26,186	40	\$ 26,186		\$ 803,208	5
6	20		1975	1975	\$ 255,191	\$ 5,843	20-40	\$ 5,843		\$ 187,985	6
7	41		1979	1979	\$ 1,323,223	\$ 31,213	40	\$ 31,213		\$ 842,348	7
8											8
	Improvement Type**										
9		Land improvements	1968		36,138	27	20-40	27		35,988	9
10		Laundry wiring-south	1980		31,442		20			31,430	10
11		Parking lot, Health Center sinks, office remodeling	1983		31,504	379	20	379		31,504	11
12		Rec room, air condit., closet doors, Gift Shop remodel	1984		200,604	6,065	20	6,065		197,559	12
13		Install computers, call light system	1985		29,244	165	12-20	165		29,012	13
14		Carpet, Health Center call light system, boiler repair	1986		16,918	145	5-20	145		16,558	14
15		Expansion tank, carpet, light flxt., closet door, windows	1987		14,030	162	5-20	162		13,493	15
16		Fire alarm system, new laundry doors	1988		30,856	742	5-20	742		27,544	16
17		Sliding doors-front entry, water softener	1989		25,488	1,132	10-20	1,132		19,265	17
18		Hot water heater, boiler repair, air condit., exam room	1990		24,368	370	10-20	370		22,853	18
19		Air condit.-2 kitchens, HC computer cab., burner/boiler	1991		44,311	2,830	15-20	2,830		36,334	19
20		Chapel speaker system, burner/boiler, carpeting	1992		27,646	548	10-15	548		26,237	20
21		Remodel dietary off., a/c coff shop, carpeting, smoke det.	1993		35,136	1,706	10-20	1,706		32,684	21
22		Air condit.-laundry, new kitchen/apt, fire alarm	1994		11,134	888	10-20	888		8,437	22
23		Remodel 1st floor hallways, air condit. Compressor	1995		12,896	1,290	5-10	1,290		10,964	23
24		Remodel of 6 rooms	1996		33,302	1,643	5-20	1,643		12,764	24
25		Remodeling of nurses station	1996		8,438	422	20	422		3,165	25
26		Boiler repair and new boiler	1996		5,363	536	10	536		4,020	26
27		Heaters	1996		1,630	163	10	163		1,223	27
28		New lights	1996		7,499	375	20	375		2,813	28
29		New windows	1996		1,762	88	20	88		660	29
30		Mixing valve and cartridge	1996		6,459	470	5-10	470		5,282	30
31		Rehab & conversion of rooms	1997		119,116	4,765	25	4,765		30,971	31
32		Remodel of Rehab dept., identicard door system	1997		37,374	1,937	10-25	1,937		12,591	32
33		Wall heaters, doors & wind., water heater, chill water sys	1997		18,338	810	10-25	810		5,265	33
34		Roof work, office remodel, clock wiring, shelving, boiler	1997		33,616	1,728	10-25	1,728		12,666	34
35		Fence along Alpine Road	1998		84,198	4,210	20	4,210		23,155	35
36		Blacktop	1998		12,538	627	20	627		3,449	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Remodel of Rehab Dept & Breakroom	1998	\$ 42,423	\$ 1,697	25	\$ 1,697	\$	\$ 9,334		37
38	Rehab resident rooms	1998	92,743	3,710	25	3,710		20,405		38
39	Rehab offices-Ex dir.,ADON, Maint., Activities	1998	36,208	1,448	25	1,448		7,963		39
40	Rear entrance door, fire protection system	1998	6,051	242	25	242		1,331		40
41	Rehab Health Ctr., Halls, Storage, Conference room	1998	24,693	988	25	988		5,435		41
42	Rehab coffee shop & gift shop	1998	4,374	175	25	175		963		42
43	Health Ctr. sound system,	1998	4,308	287	15	287		1,579		43
44	Electrical work, heating & air condit.	1998	5,180	207	25	207		1,139		44
45	Fence and grading	1999	13,566	678	20	678		3,051		45
46	Blacktop, patching, speed bumps	1999	18,220	951	10-20	951		4,279		46
47	Rehab resident rooms	1999	84,948	3,398	25	3,398		15,291		47
48	Rehab maint off., shop, laund room, housekeeping off.	1999	44,768	1,791	25	1,791		8,060		48
49	Health Ctr. Elevator conversion, emerg. Lights	1999	9,806	931	10-20	931		4,190		49
50	Windows, storm doors, boiler room electrical	1999	12,196	518	20-25	518		2,331		50
51	Rehab Health Ctr.-lighting,heat,ceiling panels,flooring	1999	33,716	1,349	25	1,349		6,071		51
52	Rehab Health Ctr.-conf room,util room,activ.air cond	1999	17,993	864	15-25	864		3,887		52
53	Rehab Health Ctr.-soc serv off., 1st floor restroom	1999	4,077	163	25	163		733		53
54	Wanderguard door alarm	1999	530	53	10	53		239		54
55	Remodel-Main office,coffee shop,gift shop	2000	1,110,762	27,769	40	27,769		97,192		55
56	Employee parking lot	2000	96,253	4,813	20	4,813		16,845		56
57	Irrigation system	2000	18,761	938	20	938		3,283		57
58	Beauty shops-1st & 3rd	2000	49,403	1,235	40	1,235		4,323		58
59	Remodel-Maint., Acctg, Activ.,& 2nd fl HC kitchen off.	2000	38,198	1,910	20	1,910		6,685		59
60	Rehab resident rooms	2000	64,544	3,588	10-20	3,588		12,558		60
61	Main entrance doors	2000	10,535	527	20	527		1,844		61
62	Roof repairs,elevator room repairs,electric,phone,comp.	2000	35,305	2,299	10-20	2,299		8,046		62
63	Back flow system	2000	65,706	3,285	20	3,285		11,498		63
64	Smoke barrier upgrade	2000	68,105	1,703	40	1,703		5,960		64
65	Vanity/Tops/Faucets	2001	8,998	600	15	600		1,500		65
66	Recaulk-main entrance/main dining/S&W wings perimeters	2001	15,040	1,504	10	1,504		3,760		66
67	Signage, OSHA modifications,HVAC modifications	2001	16,911	873	15-25	873		2,183		67
68	2nd floor remodeling-ceiling,sprinkler,lighting,duct work	2001	48,885	2,375	20-25	2,375		5,938		68
69	Rehab resident rooms,countertop,locks	2001	30,992	1,550	20	1,550		3,875		69
70	TOTAL (lines 4 thru 69)		\$ 6,821,034	\$ 198,925		\$ 198,925	\$	\$ 3,766,400		70

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTER

0027987

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,821,034	\$ 198,925		\$ 198,925		\$ 3,766,400	1
2	Miscell plants,pots,trees,mulch,sprinkler system supplies	2001	8,496	668	5-15	668		1,670	2
3	Miscell boiler room doors/frames,castings-main,a/c install	2001	4,578	374	10-25	374		935	3
4	Rehab dietary office-elect,fan coil ductwork,door	2001	7,190	360	20	360		900	4
5	Redo wall,hallway,rear stairway coping stone reset	2002	2,104	105	20	105		158	5
6	Vanity/Tops/Faucets	2002	8,106	540	15	540		810	6
7	Keys,locks,windows	2002	6,335	351	15-20	351		526	7
8	East entrance doors-structural changes	2002	7,684	384	20	384		576	8
9	Recaulk-HC wing perimeter	2002	12,695	1,270	10	1,270		1,905	9
10	Doors	2002	7,581	505	15	505		758	10
11	Laundry,south lounge,water serv valve,roof,trash chute changes	2002	9,256	1,054	5-15	1,054		1,581	11
12	Main office,conference room,training room changes	2002	4,097	205	20	205		307	12
13	Room number signs	2002	6,070	304	20	304		456	13
14	Landscaping, front entrance and east drainage	2003	6,332	277	10-15	277		277	14
15	Back parking lot-coat and seal	2003	8,175	1,363	3	1,363		1,363	15
16	Modifv patient toilet rooms and showers	2003	36,996	740	25	740		740	16
17	Garages-crown molding	2003	3,601	90	20	90		90	17
18	Screen,glass,wall,door,latches,locks replacement	2003	15,747	531	5-20	531		531	18
19	Lighting	2003	24,236	654	5-20	654		654	19
20	Vanity/Tops/Faucets	2003	4,908	164	15	164		164	20
21	Boiler room rework	2003	3,795	95	20	95		95	21
22	South wing roof	2003	66,135	1,653	20	1,653		1,653	22
23	Smoke barrier upgrade	2003	28,657	716	20	716		716	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,103,808	\$ 211,328		\$ 211,328		\$ 3,783,265	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRHAVEN CHRISTIAN RETIREMENT CENTE# 0027987 Report Period Beginning: 01/01/2003 Ending: 12/31/2003
 XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,661,432	\$ 186,862	\$ 186,862	\$	5-20 yrs.	\$ 1,502,279	71
72	Current Year Purchases	281,850	19,940	19,940		5-20 yrs.	19,940	72
73	Fully Depreciated Assets	(813,848)				5-20 yrs.	(813,848)	73
74								74
75	TOTALS	\$ 2,129,434	\$ 206,802	\$ 206,802	\$		\$ 708,371	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	25-passenger bus	Ford Turtle Top-2003	2003	\$ 56,345	\$ 2,817	\$ 2,817	\$	10 yrs.	\$ 2,817	76
77										77
78										78
79										79
80	TOTALS			\$ 56,345	\$ 2,817	\$ 2,817	\$		\$ 2,817	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,351,891	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 420,947	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 420,947	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,494,453	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Garages 1968-92,Vehicles 1989-2003	\$ 126,662	\$ 4,588	\$ 106,757	86
87	Landscaping equipment-1968-2003	49,439	2,915	45,348	87
88	Duplexes & Land Improv.1990-2003	12,159,512	367,244	4,689,467	88
89	E-wing furn.&land improv1990-2003	3,482,300	99,562	1,387,221	89
90	Land-Duplexes	411,576			90
91	TOTALS	\$ 16,229,489	\$ 474,309	\$ 6,228,793	91

G. Construction-in-Progress

	Description	Cost	
92	Construction-in-progress	\$ 18,154	92
93			93
94			94
95		\$ 18,154	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **NONE**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>All nurses aides come to Fairhaven having already completed C.N.A. classes prior to their employment. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	NONE	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 90,011	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,427)	255,233		3
4	Supply Inventory (priced at Lwr Cst or Mk)	40,780		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,280		6
7	Other Prepaid Expenses	11,056		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Limited Use Assets	182,698		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 592,058	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	473,880		13
14	Buildings, at Historical Cost	22,388,794		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,531,703		16
17	Accumulated Depreciation (book methods)	(11,705,332)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Bond Clsg Cost(Net)	113,064		22
23	Other(specify): Vehicles, CIP	183,593		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,985,702	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,577,760	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 140,593	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	295,000		29
30	Accrued Salaries Payable	255,036		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	422,023		32
33	Accrued Interest Payable	2,276		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Retirement (403-B)	17,497		36
37	Property Tax Credits Due Residents	217,520		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,349,945	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,880,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Advance Deposits on Founder's Fees	147,450		43
44	Founder's Fees	5,576,643		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,604,093	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,954,038	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 6,623,722	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,577,760	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,544,115	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,544,115	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	106,101	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes	(26,494)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 79,607	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,623,722	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,788,694	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,788,694	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,347	13
14	Non-Patient Meals	24,539	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	10,633	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	126,161	21
22	Laundry	3,251	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 169,931	23
D. Non-Operating Revenue			
24	Contributions	242,995	24
25	Interest and Other Investment Income***	2,229	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 245,224	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Duplex Income	1,554,917	28
28a	Equipment Rental & Other Income	37,891	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,592,808	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,796,657	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,589,564	31
32	Health Care	2,912,519	32
33	General Administration	1,546,331	33
B. Capital Expense			
34	Ownership	781,997	34
C. Ancillary Expense			
35	Special Cost Centers	807,585	35
36	Provider Participation Fee	52,560	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,690,556	40
41	Income before Income Taxes (line 30 minus line 40)**	106,101	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 106,101	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number **FAIRHAVEN CHRISTIAN RETIREMENT CENTER**# **0027987**Report Period Beginning: **01/01/2003**

Ending:

12/31/2003**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,864	2,080	\$ 62,711	\$ 30.15	1
2	Assistant Director of Nursing	1,904	2,080	44,823	21.55	2
3	Registered Nurses	24,020	26,090	519,636	19.92	3
4	Licensed Practical Nurses	30,587	33,217	550,759	16.58	4
5	Nurse Aides & Orderlies	98,192	105,970	1,193,297	11.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,834	11,786	127,890	10.85	8
9	Activity Director	3,563	3,920	50,868	12.98	9
10	Activity Assistants	6,480	7,143	72,030	10.08	10
11	Social Service Workers	1,266	1,507	27,536	18.27	11
12	Dietician					12
13	Food Service Supervisor	3,808	4,224	91,810	21.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,631	19,308	196,652	10.19	15
16	Dishwashers	37,904	39,859	308,537	7.74	16
17	Maintenance Workers	14,698	16,066	253,025	15.75	17
18	Housekeepers	26,476	27,887	231,552	8.30	18
19	Laundry	14,620	15,927	144,389	9.07	19
20	Administrator	1,864	2,080	85,463	41.09	20
21	Assistant Administrator	1,864	2,080	74,565	35.85	21
22	Other Administrative	1,224	1,360	35,164	25.86	22
23	Office Manager	1,864	2,080	33,704	16.20	23
24	Clerical	7,288	7,743	105,468	13.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,641	2,829	52,519	18.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	310,592	335,236	\$ 4,262,398 *	\$ 12.71	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	327	\$ 16,141	Line 1, Col.3	35
36	Medical Director	24	15,600	Line 9, Col.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,380	Line 10, Col.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	176	5,983	Line 11, Col.3	44
45	Social Service Consultant	243	12,103	Line 12, Col.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	866	\$ 51,207		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	83	\$ 3,059	Line 10, Col.3	50
51	Licensed Practical Nurses	1,347	43,484	Line 10, Col.3	51
52	Nurse Aides	316	6,091	Line 10, Col.3	52
53	TOTAL (lines 50 - 52)	1,746	\$ 52,634		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Tom Bleed	Exec. Director	0	\$ 85,463	Workers' Compensation Insurance	\$ 109,713	IDPH License Fee	\$				
Jeff Reiersen	Asst. Administrator	0	74,565	Unemployment Compensation Insurance	32,475	Advertising: Employee Recruitment	3,595				
Steve Hemenway	Dir. Of Human Resources	0	35,164	FICA Taxes	312,629	Health Care Worker Background Check (Indicate # of checks performed 83)	998				
				Employee Health Insurance	375,496	LSN Membership Fees	10,497				
				Employee Meals	11,063	Required Minority Advertising	395				
				Illinois Municipal Retirement Fund (IMRF)*		Profess & Business Related Subscript.	4,025				
				403-B Annuity Expense-Company Match	73,830	IL CPA Society Dues	295				
				403-B Annuity Admin. & Trustee Serv-Amcore	4,106	State Licenses	605				
				Company Appreciation Events	11,661	Promotional & Advertising Fees	18,684				
				Employee Physicals	3,030	Less: Public Relations Expense	(2,654)				
						Non-allowable advertising	(14,496)				
						Yellow page advertising	(1,534)				

* Attach copy of IMRF notifications

****See instructions.**

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network(LSN) \$10,497
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 8 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47,513 Line 10 (Col.2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 52,560
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? NONE
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 11,063 Has any meal income been offset against related costs? YES Indicate the amount. \$ 13,251
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: BDO Seidman,LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A<\$2,500
Attach invoices and a summary of services for all architect and appraisal fees.

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987

1/1/03 - 12/31/03

RECLASSIFICATIONS:

LINE 2	Food purchase	<u>\$ (11,063)</u>	Take out cost of meals provided to employees
LINE 5	Heat & other utilities	<u>\$ (5,000)</u>	Take out utilities allocable to beauty shop
LINE 19	Professional services	\$ (998)	Take out background checks
		\$ (3,030)	Take out employee exams
		\$ (4,106)	Take out 403-B administration function
		<u>\$ (8,134)</u>	
LINE 20	Fees, subscriptions, & promotions	<u>\$ 998</u>	Add in background checks from line 19
LINE 22	Employee benefits & payroll taxes	\$ 11,063	Add in cost of meals from line 2
		\$ 3,030	Add in employee exams from line 19
		\$ 4,106	Add in 403-B administration function from line 19
		<u>\$ 18,199</u>	
LINE 26	Insurance-Property & Liability	<u>\$ (15,000)</u>	Take out insurance-property for Duplexes
LINE 30	Depreciation	<u>\$ 6,444</u>	Add in additional depreciation relating to Duplexes
LINE 40	Barber & Beauty Shops	<u>\$ 5,000</u>	Add in utilities taken out of line 5
LINE 43	Other-Duplexes	\$ 15,000	Add in insurance-property from line 26
		\$ (6,444)	Take out depreciation from line 30
		<u>\$ 8,556</u>	
TOTAL		<u>\$ -</u>	

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987

1/1/03-12/31/03

Schedule V p. 3 & 4

LINE 7

Security Services	\$ 118,368
Trash Disposal	\$ 13,874
	<u>\$ 132,242</u>

LINE 36

Amortization of Bond Closing Costs	<u>\$ 12,448</u>
------------------------------------	------------------

LINE 43

Duplexes: Real Estate Taxes	\$ 352,026
Depreciation	\$ 367,244
Utilities	\$ 45,381
Maintenance	\$ 36,490
Insurance	\$ 15,000
	<u>\$ 816,141</u>

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987

1/1/03 - 12/31/03

Sch VI p. 5

LINE 29

Gas for Non-Care Vehicles	\$	(466)
Insurance for Non-Care Vehicles	\$	(138)
Flowers & Decorations, Miscellaneous	\$	(3,313)
Bond Trustee Costs	\$	(23,245)
Real Estate Taxes - Main Building	\$	(217,040)
	\$	<u>(244,202)</u>

LINE 45

Duplex Insurance	<u>\$15,000</u>
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FAIRHAVEN CHRISTIAN RETIREMENT CENTER
#0027987 1/1/03 - 12/31/03

Sch XVII Income Statement Page 19

E. Other Revenue

Line 28	<u>\$ 1,554,917</u>	Duplex Monthly Maintenance and Founder's Fee Income
Line 28a	\$ 8,322	Equipment Rental-Wheelchairs & Gerichairs
	<u>\$ 29,574</u>	Other Income such as Vending Machine, Monthly Cable, Activities, Gain on Sale
	<u><u>\$ 37,896</u></u>	

FAIRHAVEN CHRISTIAN RETIREMENT CENTER

#0027987 1/1/03-12/31/03

PAGE 10B: 2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

EXPLANATION REGARDING PAGE 10A PARTS B & C:

- B. Our tax bills relate to property that is not directly used for nursing home services, such as duplex living and independent living in the main building. None is allocated to the nursing home section since it is exempt from real estate taxes.
- C. No tax bills have been attached to this report since all of our company real estate tax has been adjusted out.